

HPR I REGIONAL ADMISSIONS PROTOCOL

Serving the individuals and communities for the following Community Service Boards (CSBs):

Harrisonburg-Rockingham Community Services Board, Horizon Behavioral Health, Northwestern Community Services, Rappahannock Community Services Board, Rappahannock Rapidan Community Services, Region Ten Community Services Board, Rockbridge Community Services Board, and Valley Community Services Board.

Section 1: Purpose and Expectations

It is of critical importance to achieve a safe placement for individuals in crisis within the time limit afforded by the Code of VA. Clear and consistent procedural expectations are to be established among the stake holders of HPR I to define what steps are to be taken to seek TDO admissions to private psychiatric hospitals. This protocol establishes the process to be followed when a private hospital bed is not readily available and an admission to a state hospital is necessary. By establishing this protocol, it is the goal of HPR I to find appropriate placement for all TDO eligible individuals within the allotted time frame and to ensure that no one who requires a TDO admission be released to the community without receiving adequate treatment. This protocol applies to all potential TDO admissions, whether subject to an Emergency Custody Order (ECO), or not.

Section 2: Preadmission Screening Procedure

As mandated by VA Code, a law enforcement officer taking Emergency Custody of an individual for the purpose of a preadmissions screening assessment will contact the local CSB Emergency Services program as soon as is practicable to notify them of the need for an assessment (contact information for HPR I CSB Emergency Services programs can be found in Appendix B). The CSB prescreener will then respond to the appropriate ECO location to begin the process of the preadmissions screening assessment as quickly as possible. Historically, response time guidelines have suggested a response of one hour or less for urban CSBs and two hours or less for rural CSBs.

In addition, VA Code requires that all individuals taken into emergency custody will be provided with a written summary that explains the ECO procedure. *This summary will be provided to the individual by the law enforcement officer who takes the individual into custody as soon as is practicable upon taking emergency custody of that individual.*

Once the CSB prescreener is notified of the pending preadmissions screening evaluation, they will then contact the appropriate state hospital to notify the state hospital that the individual being evaluated will be transported to that facility upon issuance of a temporary detention order (TDO) if no other facility of temporary detention can be identified by the end of the ECO period, or 8 hours from the start of the preadmission screening assessment in cases where an ECO was

not issued but a TDO admission is required. The state facility should receive notification of the need for a prescreening as soon as possible but no more than one hour from either the beginning of the ECO period or from the request of the preadmission screening assessment when an ECO has not been issued but a TDO admission appears likely.

In addition, the appropriate state hospital is to be notified upon the completion of the preadmission screening assessment. When a TDO admission is indicated by the prescreening assessment and, in the clinical judgment of the prescreener appears likely to necessitate a state admission, the completed preadmission screening form should be sent via FAX to the state facility, along with a notification phone call. The state hospital may perform their own search for an alternate hospitalization in collaboration with the CSB prescreener and, if successful, will notify the CSB prescreener immediately that a willing private hospital has been located.

Section 3: Procedures for Seeking Private Hospital Beds for TDO Admissions

HPR I is comprised of eight CSBs that cover a large and diverse area. Over the years, the ES department at each Board has developed working relationships with a number of private hospitals. These hospitals typically are the ones closest to the CSB geographically, recognizing the best practice of hospitalizing individuals close to home and family as best as possible in order to enable families to better participate in treatment and discharge planning when appropriate. However, CSBs also have established strong relationships with private hospitals, both within the HPR I service area and outside it, that have LIPOS contracts with HPR I and utilize them for TDO admissions frequently.

The CSBs will use the standard list of private hospitals listed in the Psychiatric Bed Registry (PBR) but may prioritize their own order of this list rather than attempting to create a “one size fits all” list of hospitals for all to use. This will allow each Board to continue to best serve their clients by utilizing those hospitals nearest to them in proximity or that have the best working relationships with them by calling them first to seek admission.

If TDO admission is the indicated disposition of the preadmission screening evaluation, the steps taken by a CSB prescreener to secure a private TDO admission are as follows:

Step 1: Private psychiatric hospitals *and Crisis Stabilization Units (CSUs) as appropriate* with reported bed availability per the PBR will be contacted first to secure a TDO bed. For the sake of timeliness and to maximize the number of private hospitals that can be called, it will be necessary for the prescreener to contact a number of these hospitals simultaneously to request a bed. Unless indicated otherwise, bed searches will begin with those facilities in close proximity to the prescreening CSB and/or those with LIPOS contracts with HPR I. If none of these facilities are able to admit the individual, other appropriate facilities across the state may be contacted for possible admission.

It is the expectation of this protocol that hospitals will work to give responses regarding admissions (either approving admissions or declining) as promptly as possible. Once an admission is secured, the prescreener should contact the appropriate state hospital to cancel the potential request for a bed.

Step 2: If the search of the PBR hospitals with reported bed availability is unsuccessful, the prescreener may then begin to contact hospitals listed on the PBR that currently are not showing bed availability, particularly those that may not have updated bed status on the PBR recently, to seek admission.

For each prescreening, the CSB prescreener will document which private hospitals were called, the time the calls were initiated, the response received and the time of the responses. This documentation will be in accordance with the CSB's policies and will be particularly important should the case need to be reviewed as part of the Quality Improvement process (see Section 12). The PBR will also document the process for each individual bed search in addition to those records kept by the CSB and the PBR records may also be reviewed for Quality Improvement purposes.

Section 4: Procedures for Seeking State Hospital Beds When Private Beds are Unavailable

When the ECO reaches the six hour mark from the time it was executed and a private hospital bed has yet to be secured, a call will be made by the prescreener to the state hospital to notify admissions staff that a TDO bed search is in process and the bed search is extending past six hours. In prescreenings that do not involve an ECO, this six hour limit will still apply and will be measured from the time the preadmission screening process commences. It should be emphasized that this call is not made to necessarily seek admission at the state facility at that time but rather to continue the collaboration with the state facility and the discussion of admission should it become necessary.

If, after collaboration between the CSB prescreener and admissions staff at the state hospital, it appears that no private beds are available and a state bed will be sought, the CSB prescreener may notify their ES Manager or Designee, in accordance with CSB procedures, to discuss a possible request for admission to the state facility. The ES Manager or Designee will review the request with the prescreener and, as appropriate, will authorize the prescreener to contact the state hospital to formally request admission. This review will include factors such as availability of willing private facilities, as well as medical appropriateness, substance abuse issues, and other factors that may impact the safety of the individual and indicate appropriateness for admission to a state hospital.

If no private psychiatric bed has been identified by the seven hour mark, the prescreener will notify the appropriate state facility that a TDO admission is being sought at that facility. The state facility admissions staff will notify the prescreener ASAP when admission has been approved to allow adequate time for the prescreener to pursue the TDO from the Magistrate. The

formal process of securing the TDO from the Magistrate should begin no less than thirty minutes before the expiration of the ECO (or seven and a half hours from the start of the assessment for non-ECO assessments) in order to ensure TDO disposition within the allowable time parameters.

If the state facility is unable to accept the patient due to capacity issues, it shall be the responsibility of the state facility director, or his or her designee, to arrange admission to another state facility that has an available and appropriate bed. Alternate disposition is to be established and the TDO obtained by the end of the ECO period or eight hours from the initiation of the prescreening assessment in non-ECO prescreening assessments.

It is understood that, under no circumstance, should an individual who is medically appropriate and who meets TDO criteria be released from an ECO without an admission to a psychiatric facility and the disposition should not take longer than the maximum time period allowed by VA Code for an ECO (8 hours).

Section 5: Medical Assessment and Medical Screening Procedural Expectations

The purpose of this process is, essentially, threefold: 1) to determine that the individual who is being prescreened is not in any imminent medical danger, 2) to determine that apparent psychiatric symptoms are not the result of underlying medical factors, and 3) to help determine an appropriate facility, if hospitalization is warranted, that will have the capacity to safely manage any medical issues that the individual may have.

A basic Medical Assessment of an individual who is the subject of a preadmission screening may include the following:

- Physical Exam
- CBC
- Urinalysis
- Comprehensive Metabolic Panel
- Urine drug screen and blood alcohol level
- EKG (if indicated)

Based upon the results of the above assessment (if indicated) and/or the individual's medical history, other testing may be required before the individual can be assessed as medically appropriate for admission to a psychiatric facility. If further testing or assessment is required for admission to be considered, it is expected that the potential receiving facility communicate this to the CSB preadmission screener ASAP. The CSB preadmission screener will notify the medical staff performing the Medical Assessment of this request ASAP in order to maximize the use of the time allotted under the Emergency Custody Order.

In many cases, there will be potential dispositional issues regarding medical appropriateness for psychiatric admission between the physician performing the Medical Assessment/Screening and

the physician at the potential receiving psychiatric hospital. Because the ability to appropriately resolve these issues typically requires a level of medical training that far exceeds that of most CSB preadmission screeners, differences of opinion regarding medical appropriateness will require a direct physician to physician consultation. A physician's designee may also suffice for this purpose, provided that the hospital's policies allow for that. The CSB prescriber is to facilitate this consultation to the extent possible (e.g. provide facility phone numbers, etc.) but will not be required to ultimately resolve the medical screening issue. It is recommended that all communications related to medical screening and assessment be documented in accordance with CSB policy.

All policies and procedures related to medical screening and assessment will be in accordance with the "Medical Screening Guidance" document issued by DBHDS in April, 2014.

Section 6: Accessing HPR I REACH Program in Cases Involving Individuals with ID/DD

In any preadmission screening involving an individual with either documented or suspected Intellectual Disability(ID) and/or Developmental Disability (DD), the HPR I REACH program will be contacted and advised of the prescreening as outlined in each CSB's Linkage Agreement with the HPR I REACH (formerly START) program. Contact information for the REACH program can be found in Appendix B of this document.

It is understood that REACH may not be able to divert a psychiatric admission at the time of the preadmission screening. However, a REACH consultation may indicate additional resources to resolve the crisis or, in many cases, begin the process of expediting discharge planning or facilitate a step-down admission to the REACH therapeutic home for an individual with ID/DD. Additionally, for individuals with ID or DD admitted to Western State Hospital, in order to ensure the most appropriate treatment options, the regional protocol entitled "HPR I ID/BH Crisis Coordination Memorandum of Agreement" (see Appendix A) may be utilized for coordination of services between the local CSB, Western State Hospital and Central Virginia Training Center.

Section 7: Substance Abuse and/or Intoxicated Individuals

Substance use and/or intoxication are not exclusionary criteria for admission to a state facility unless the individual is medically compromised or in need of medical detoxification. WSH does not admit individuals who are intoxicated **and** have a history of significant withdrawal symptoms (i.e., seizures, DT's). WSH does not have the capability for intubation or providing ventilator support or inserting IV's if the need should arise. There is no specific cut-off point for BAL. An individual cannot be admitted if he/she is obtunded or is having difficulty breathing or regulating their airway or have an underlying medical condition that cannot be appropriately treated at WSH. Individuals with such circumstances will be subject to the guidelines involving medically-compromised individuals as established in Section 5 of this protocol.

Section 8: Individuals Who Are Deaf

While individuals who are deaf or otherwise hearing-impaired may have specialized needs in terms of treatment, the Admission Protocol should be followed as for any other adult person with private facilities to be sought for admission whenever possible. As mandated by State Code, VDDHH (Virginia Department for the Deaf and Hard of Hearing) maintains a directory of Qualified Interpreter Services and works to remove communication barriers. DBHDS, in cooperation with the CSBs, provides comprehensive consultative services; contact Kathy Baker, Coordinator of Services at 540/213-7527.

Section 9: Children and Adolescents

As is the case with adults needing TDO admission, CSB prescreeners will seek admission to private psychiatric facilities for children and adolescents following the same process as outlined in Section 2 above. However, if no private facilities are available for admission for children and adolescents, a placement at Commonwealth Center for Children and Adolescents (CCCA) will be sought in accordance with the CCCA Admissions and Bed Management Plan of June 2014 (attached).

Section 10: Geriatric Admissions

HPR I is served by two different state facilities for treatment of geriatric patients (defined as having reached age 65 or older). Rappahannock CSB, Rappahannock-Rapidan CSB, and Region Ten CSB are served by Piedmont Geriatric Hospital, while Harrisonburg-Rockingham CSB, Horizon Behavioral Health, Northwestern CSB, Rockbridge CSB, and Valley CSB are served by the geriatric unit of Catawba State Hospital.

The procedures for seeking a psychiatric admission for a geriatric individual will, in many ways, follow the same steps indicated for seeing admissions for adult patients in Sections 2 through 4 of the Regional Admissions Protocol document. Private psychiatric hospitals that specialize in geriatric care (as listed on the PBR) should be sought first for admission whenever possible.

However, because geriatric admissions often present an increased likelihood of challenges, particularly related to medical screening and assessment issues, contact should be made with the appropriate state geriatric facility earlier in the process to allow the state facility more time to adequately process the referral in a manner that is conducive to the safety of the patient and the appropriateness of the placement.

When seeking a psychiatric admission for a geriatric individual and a bed at a private facility has not been found, the CSB prescriber will contact the state geriatric facility (Catawba or Piedmont, depending on the CSB) at the 5 hour mark of the ECO (or prescreening) process. This call is made to notify the geriatric facility that an admission may be needed at the state facility so that the state facility can begin the process of reviewing the admission materials.

Following this notification call, the prescriber will continue to pursue admission at appropriate private facilities, utilizing the Psychiatric Bed Registry to help identify facilities that may have beds suitable for geriatric patients. However, if the ECO/prescreening process reaches the 6 1/2 hour mark without a willing private admitting facility identified, the CSB prescriber will contact his/her ES Manager (or designee), who will then contact the Facility Director, or designee, at either Catawba Hospital or Piedmont Geriatric Hospital (depending on the CSB) to secure a safety net bed.

Once the Facility Director/designee is notified, the approval process for a bed at the geriatric facility continues, with review by the physician and nursing supervisor.

The Social Work Director during the day or the Nursing Supervisor afterhours notifies the CSB of acceptance.

If no safety net bed is available at the designated facility, the Facility Director, or designee, will contact other geriatric state facilities for possible placement. Alternate placement is to be determined prior to the end of the ECO period or 8 hours from the initiation of the preadmission screening assessment for individuals not under an ECO but who require a TDO admission.

Section 11: State Hospital Bed Utilization

Critical to the success of any regional admissions protocol is the demonstrated ability to derive the maximize benefit from a limited pool of resources. This is especially true of the need to keep potential state hospital “safety net” beds open to the greatest extent possible in order to make certain they are available to accommodate emergency TDO admissions when they are needed. To keep these beds free as possible, it is imperative to monitor bed utilization in the state hospitals from admission to discharge.

HPR I has historically been proactive in terms of bed utilization reviews at Western State Hospitals. CSB Liaisons meet on a monthly basis to review WSH patients who are either ready for discharge or are approaching readiness for discharge in order to collaborate to achieve successful and timely discharges from WSH as appropriate.

When an individual is admitted to WSH on a direct TDO due to lack of availability of a private hospital bed, the CSB who performed the preadmission screening will notify the HPR I Regional Initiatives Director via email no later than the start of the next business day. The Regional Initiatives Director will monitor and track all direct TDO admissions during their stay at WSH and will collaborate, as appropriately, with the case management CSB and WSH to help facilitate discharge or transfer to either a private hospital or CSU, if clinically indicated. The Regional Initiatives Director will also maintain records of all direct TDO admissions to WSH, including date of admission, length of stay, and final disposition. This information will be reported to the HPR I Executive Director Forum, the HPR I UMT group, and the HPR I CSB Liaisons to WSH at regularly-scheduled meetings of these groups.

Section 12: Quality Improvement and Review

For a Regional Admissions Protocol to be successful and be adaptive to ongoing changes to legislation, private and state psychiatric hospital resources, and CSB resources, among other changes, there needs to be an active and robust Quality Improvement and Review process. The practical effectiveness and overall success in reaching its goals needs to be assessed on a regular basis, with feedback from every stakeholder involved in the TDO process. In addition to ongoing protocol development, the Quality Improvement process must also be responsive to resolving problems that may arise in the implementation of the protocol in a timely fashion, in order to prevent these problems from re-occurring to the greatest extent possible.

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) requires each CSB to submit monthly reports of any instances involving TDOs that, for whatever reason, extended past the allotted 8 hour ECO period or that were not issued when required. These reports are submitted to the HPR I Regional Initiatives Director who reviews and compiles the data before submitting a regional report to DBHDS. This data is instrumental as a barometer of success of the Regional Admissions Protocol and will be reviewed regularly by all involved stakeholders as part of the ongoing quality improvement and review process. In cases where a TDO admission was required but was not achieved, the CSB Executive Director is to be notified as soon as possible, and is required to submit a written notification of this event to DBHDS within 24 hours of the event.

In HPR I, there currently exists organizational infrastructure that would appear to be well-suited for overseeing and administering much of the Quality Improvement process. Specifically, these would be the Regional Access Committee (RAC), the Utilization Management Team (UMT), and the Executive Directors (ED) Forum.

The RAC is composed of representatives from the eight CSBs in HPR I (typically from the Emergency Services department), representatives from the Admissions Department at Western State Hospital, the HPR I ID/DD Project Manager, and the HPR I Regional Initiatives Director. While private psychiatric hospitals do not actively participate in RAC, each CSB RAC representative is responsible for communicating and collaborating with private hospitals for cases involving individuals served by their Boards. This group meets twice each week (on Tuesday and Thursday mornings, with the exception of holidays) via conference call, but also has the ability to meet at other unscheduled times on an emergency basis as the need arises. The primary purpose of the RAC is to review potential transfers of patients from private psychiatric facilities to Western State Hospital, taking into consideration appropriateness for transfer as well as the triaging of potential transfers bases upon severity of need, acuity and dangerousness, etc. In addition, cases involving direct TDO admissions to Western State Hospital (due to lack of private hospital bed availability or other factors) are discussed in the RAC call. Because this group meets very frequently and involves so many stakeholders, it would seem logical that this group would be the first place to discuss cases that involved problematic TDO cases. If

necessary, the Regional Initiatives Director will reach out to any and all private psychiatric hospitals that were involved in the case to seek further information and input from the hospitals. The RAC representative from the CSB that performed the preadmission screening in question will be responsible for staffing the problem TDO with the RAC group at the soonest RAC conference call. Through collaboration and constructive problem-solving, it is expected that the majority of problem cases will result in resolution and, in some cases, suggestions for potential changes to the protocol. In all cases, the Regional Initiatives Director will notify the hospitals and CSBs that were directly involved in the problem TDO and what, if any action is recommended by the RAC team.

The UMT meets bimonthly (every other month) and is a larger group, composed of the same individuals in RAC, plus representatives from private psychiatric hospitals, HPR I regional Crisis Stabilization Units (CSUs), representatives from DBHDS, and other CSB staff, including Mental Health Directors, etc. The primary function of this group is to review the utilization of resources in HPR I to make certain that they are being used in the most effective and efficient manner possible. The HPR I Regional Initiatives Director will report, at each UMT meeting, any problem cases that were reported to and discussed by RAC, as well as provide information regarding the resolution and disposition of the cases as available. The UMT group will be tasked with providing continuous oversight of the Regional Admissions Protocol and its effectiveness and will serve as an advisory group to the HPR I Executive Directors Forum to provide any input, suggestions, or recommendations regarding potential modifications to the Regional Admissions Protocol.

The HPR I Executive Directors Forum meets on a monthly basis and, as its name implies, is composed of the Executive Directors of the eight CSBs in HPR I. However, this meeting is also attended by other stakeholders, including (but not limited to) DBHDS, Western State Hospital, the Commonwealth Center for Children and Adolescents, Central Virginia Training Center, and the HPR I ID/DD Project Manager and the HPR I Regional Initiatives Director. The HPR I Regional Initiatives Director will include, in his monthly report to the ED Forum, discussion of problem TDO cases that were discussed by RAC and/or UMT, including dispositions and protocol revision suggestions as appropriate. The HPR I ED Forum is the organizational body responsible for establishing regional protocols and will make the final decision regarding the content of the Regional Admissions Protocol, as well as any modifications made to the protocol moving forward.

In addition, the CSBs of HPR I plan to form a work group tasked with reviewing Emergency Services protocols and procedures, in general, to promote and maintain the incorporation of national standards.

Signed:

Nancy Cottingham, CEO, Horizon Behavioral Health

Date

Robert Johnson, Executive Director, Region Ten CSB

Date

David Deering, Executive Director, Valley CSB

Date

Brian Duncan, Executive Director, RRCSB

Date

Lacy Whitmore, Jr., Executive Director, HRCSB

Date

Ron Branscome, Executive Director, Rappahannock Area CSB

Date

Dennis Cropper, Executive Director, Rockbridge Area CSB

Date

Millard Hall, Executive Director, Northwestern CSB

Date

Dr. Jack Barber, Director, Western State Hospital

Date

APPENDIX A

Health Planning Region I ID/BH Crisis Coordination

Memorandum of Agreement

Purpose:

The purpose of this agreement is to provide procedures for HPR I CSBs, Central Virginia Training Center (CVTC), and Western State Hospital (WSH) to determine where and how individuals in crisis and needing institutional emergency services would best be served. This agreement will allow for fluid movement between the intellectual disability and behavioral health systems for those persons in crisis.

Region I ID/BH Crisis Coordination Program

This procedure is designed to assure access to institutional emergency treatment services for those individuals who have a dual diagnosis of intellectual disability / behavioral health (ID/BH) or who have intellectual disability and are experiencing severe behavioral or emotional crises. These individuals often are turned away from the local hospitals or alternative community placements. Referrals would come from Emergency Services workers.

Referrals would include those persons with dual diagnosis and persons with intellectual disability who are in immediate crisis, whose behaviors pose risks of danger to self or others, and whom the community providers cannot or will not accept.

Procedures:

A. Initial Response (Refer to Region I's CSB Protocol)

B. Emergency Admissions to Private Hospitals

Community hospitals are a consideration for individuals with dual diagnosis or individuals with intellectual disability and severe behavioral issues. The CSBs will maintain a list of community providers and hospitals with pre-established agreements to provide short term emergency services. It is agreed that at the end of this short term inpatient service, the individual will return to the community again if stable and assessed as ready for discharge. In the event the person continues to display disruptive behaviors, an assessment team from CVTC may screen the individual and recommend the most appropriate facility or facilities for placement. The DSM IV-TR diagnostic criteria will be used to determine a diagnosis of Mental Retardation / Intellectual Disability.

If the CSB believes that the individual is in need of further inpatient psychiatric treatment, then it will make a referral for HPR I/WSH Regional Authorization Committee (RAC) review. RAC may request a consultation by CVTC staff through the CVTC Coordinator of Community and Social Services, to evaluate the individual. Those persons identified with an Axis I disorder considered

appropriate by the Community Service Performance Contract and RAC will be considered as requiring psychiatric treatment, although placement at CVTC may be a consideration if this is most appropriate for the individual.

C. Admission Procedures to Western State Hospital

Civil admissions will be limited to individuals residing in the HPR I catchment area. The admitting diagnosis will be established by a qualified CSB staff member. Once the diagnosis has been determined for referral criteria, there will be no further debate regarding primary axis determination. The WSH Admissions Coordinator will arrange for admission during regular business hours. Referrals are only coordinated by the CSB Emergency Services.

- The CSB Emergency Services worker will ensure that the Prescreening Form is complete and as accurate as possible with appropriate primary Axis I diagnosis identified.
- All applicants must be medically screened prior to admission.
- Those individuals with dual diagnosis who have been assessed to be functioning in the moderate or mild range of mental retardation will be referred to WSH when it appears crisis issues are psychiatric in nature. These individuals will generally have an assessed IQ above 50.
- Individuals with dual diagnosis who have been assessed to have an IQ at 50 or below will be referred to CVTC when the issues are not psychiatric in nature.
- If, after consultation with the Admission Coordinator at WSH, it is determined that WSH may not be appropriate, the CSB will then contact the Coordinator of Community and Social Services at CVTC to discuss the most appropriate placement.
- Admission will be by Temporary Detention Order (TDO) to WSH if the person is in crisis has a dual diagnosis of ID/BH or a provisional psychiatric diagnosis and has an IQ score generally above 50.
- Within the timeframe of the TDO an assessment and initial treatment plan will be completed by medical/psychiatry staff at WSH to determine, if possible, the primary cause of the disruptive behavior or altered mood, and rule in/out psychiatric conditions as the primary cause of the crisis. Once this determination is made, WSH will consult with the CSB case manager and proceed with either continued hospitalization at WSH or request that the CSB begin the referral process to appropriate programs or locations.
- CSB case manager, WSH, and CVTC will discuss options and agree on the appropriate placement.
- The Civil Commitment hearing will be coordinated and scheduled at WSH and any medical/psychiatric findings will be presented. WSH and the CSB will enter the hearing with either: (1) a recommendation for no Civil Commitment or (2) a recommendation for Civil Commitment whether to a local community hospital or WSH or (3) a recommendation for CVTC emergency admission in coordination with WSH and CVTC. If the person is not committed, discharge arrangements will be coordinated with the CSB.

Emergency Admission Procedures to Central Virginia Training Center

If the decision is made that the individual is more appropriate for CVTC or placement at WSH is denied at the Civil Commitment Hearing and treatment is still felt to be needed, the qualified CSB staff would then complete the CVTC Emergency Care (21-Day) Admission Intake Form and submit this to the Coordinator of Community and Social Services at CVTC. Weekend, holiday or after-hour requests for admission will be held until the next working day. Following notification, the

Coordinator of Community and Social Services or designee will follow all routine admission procedures as described below.

- A completed CVTC Emergency Care (21-Day) Admission Intake Form with attachments and all other relevant materials shall be forwarded to the Coordinator of Community and Social Services, CVTC, for admission review and consideration.
- All applicants must be screened prior to admission by CVTC staff.
- The application is reviewed by the Coordinator of Community and Social Services, CVTC, who coordinates the Admission Management Committee review.
- The Coordinator of Community and Social Services then reports back to the Director of CVTC with the Committee's recommendations.
- Pending the CVTC Director's approval, the Coordinator of Community and Social Services notifies the CSB case manager of the decision.
- All individuals accepted to CVTC using the above procedure will be accepted on a 21-day emergency basis.
- No one can come to CVTC with legal charges of any kind pending.

D. Transfers Between Participating State Facilities

CVTC Emergency admissions may begin, by necessity, at WSH due to the time of the request made by the CSB case manager. The CSB case manager and WSH may agree, at the time of the admission, that WSH is not the most appropriate site for treatment.

- Upon Admission to WSH, if CVTC has not been notified due to time of admission (i.e. after-hours, weekend, holiday), the CSB case manager will notify the CVTC Coordinator of Community and Social Services of the admission by 10 a.m. next business day.
- A request for a screening and transfer will be made by WSH to the CVTC Coordinator of Community and Social Services.
- A screening by CVTC staff will be scheduled within 2 business days and communicated to WSH requesting staff by the end of the next business day.
- WSH will fax all documentation pertinent to the transfer request prior to the scheduled date of the screening.
- CSB case manager will complete the appropriate admission documentation and forms, depending on what type of admission is requested, and fax to CVTC prior to the scheduled date of the screening by CVTC.
- The ID Case Manager or designee will be present (in person, by telephone, or videoconference) for the scheduled screening.
- A determination regarding acceptance of the transfer by CVTC will be made and communicated within 1 business day of the screening.

Individuals that are screened for a psychiatric Emergency Admissions to WSH, may later require further stabilization at CVTC.

- WSH will contact the CSB case manager to discuss options with the ID Case Manager.
- After it has been determined by the WSH treatment team that the individual has received maximum inpatient psychiatric treatment benefit, a request for a screening and transfer will be made by WSH to the CVTC Coordinator of Community and Social Services.
- A screening by the CVTC team will be scheduled within 5 business days and communicated to the WSH requesting staff person by the end of the next business day.

- WSH will fax all documentation pertinent to the transfer request prior to the scheduled date of the screening.
- CSB case manager will complete appropriate admission documentation and forms, based on what type of admission is requested, and fax to CVTC prior to the scheduled date of the screening by CVTC.
- The ID Case Manager or designee will be present (in person, by telephone, or videoconference) for the scheduled screening.
- A determination regarding acceptance of the transfer by CVTC will be made within 2 business days of the screening. Notification of this decision will be communicated that same day.

E. Discharge Planning

All services provided at CVTC or WSH will attempt to stabilize individuals and return them to the community as soon as possible. The decision that an individual is ready for discharge is made by the treatment team (i.e., facility staff, CSB staff, individual and family members, as practicable). All parties will follow the discharge protocol.

F. Appeal Process

If the decision for emergency care admission is denied by the Committee, the Executive Director of the requesting CSB may appeal the Committee's decision to both Facility Directors and have turnaround response within 1 business day.

G. Reporting/Monitoring

The Central Virginia Training Center Coordinator of Community and Social Services and the Western State Hospital Admission Director will monitor the implementation of this agreement, provide data to the clinical directors and the directors of their respective facilities and make recommendations as to any reasonable corrective actions.

H. Review of Memoranda of Agreement

This document will be in effect for one year from date of signatories and automatically renew for 4 consecutive years thereafter, unless otherwise terminated by one party in writing. Review of said document will take place by all signatories on an annual basis from the date of signatures and will be initiated by HPR I Regional Initiatives Manager.

APPENDIX B

CSB EMERGENCY SERVICES CONTACT PHONE NUMBERS

Harrisonburg-Rockingham CSB	540-434-1766	
Horizon Behavioral Health	434-847-8035 (Adults)	Business Hours
	434-948-4831 (Child/Adolescent)	Business Hours
	434-845-9404 (Adults)	After Hours
	434-522-8191 (Child/Adolescent)	After Hours
Northwestern CSB	540-635-4804 (select Option 1)	Business Hours
	540-722-5184	After Hours
Rappahannock CSB	540-373-6876	
Rappahannock Rapidan CSB	540-825-3100	Business Hours
	540-825-5656	After Hours
Region Ten CSB	434-972-1800	
Rockbridge CSB	540-463-3141	Business Hours
	540-463-7328 (Rockbridge Co)	After Hours
	540-261-6171 (Rockbridge Co)	After Hours
	540-839-2375 (Bath County)	After Hours
Valley CSB	540 885-0866	

STATE PSYCHIATRIC FACILITY ADMISSIONS CONTACT NUMBERS

<u>FACILITY</u>	<u>PHONE</u>	<u>FAX</u>
CATAWBA STATE HOSPITAL (Business Hours)	540-375-4300	540-375-4399
(After Hours)	540-375-4711	
COMMONWEALTH CENTER FOR CHILDREN AND ADOLESCENTS	540-332-2120	540-332-2202
PIEDMONT GERIATRIC HOSP. (Business Hours)	434-294-0112	434-767-2352
(After Hours)	434-767-2352	*
*will be provided admissions staff		
WESTERN STATE HOSPITAL (Business Hours)	540-569-3187	540-332-8144
(Business Hours)	540-569-3189	
(After Hours)	540-332-8001	540-332-8614

REACH PROGRAM CONTACT NUMBER

REACH	1-855-917-8278
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